Not a Monster

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Preface

The Cluster B disorders are:

1) Borderline personality disorder (BPD)
2) Narcissistic personality disorder (NPD)
3) Antisocial personality disorder (ASPD)
4) Histrionic personality disorder (HPD)

Some people with Cluster B disorders prefer the phrase “person with NPD”, “person with BPD,” “person with ASPD”, or a “person with HPD”. In my work, I have used the words *sociopath*, *anti-society*, *narcissist*, *histrionic* and *borderline* to describe myself and members of the Cluster B community. I used to regard the identity-first label of borderline as offensive, until I realised that there is nothing wrong with having BPD and welcomed the disorder as an integral part of me. Readers without ASPD and NPD, the terms *sociopath* and *narc* can only be claimed by those with ASPD and NPD respectively. A slur can only be claimed by the community denoted by the slur.

I want to stress that I wish I could cover everything there is to know about the Cluster B community and the harm we endure, but then I would never be able to finish this writing and successfully publish it. A short, finished piece of work is more important than a dusty tome. This writing is meant to be short, concise, clear, introductory, and easily accessible. Enjoy!

Chapter I

I Am Human

It would seem this is not common knowledge, but the people denying the fact are as aware of it as anyone else. They merely prefer wilful ignorance, which is a shame. Their cloak of denial shields them from their own sins and ignorance. So much unity between fellow human beings could come from embracing the truth.

Below is a truth as obvious as the fact that the sky is blue and the leaves green.

I am human.

Even if I am a sociopath, a narcissist, and a borderline.

I would love to repeat it to you, dear reader, so that your brain may process what I am saying.

I am human. No, I am not a monster.

Chapter II

Oppression

I embrace Ruby, in all her entirety, from her uniqueness to her beauty.

I embrace who I became to survive the childhood I did not deserve. A childhood of violence, screams, ego, and neglect.

For that, I do not require anyone's acceptance or validation. The mere fact that I escaped my abusive environment, and overcame homelessness, financial insecurity, and harassment from my abuser validates that I am strong and persevering. I challenged my abusers and the system as a sociopath, narcissist, and borderline, and most importantly as a trauma survivor.

To all the people who inspired me to write this because I had the misfortune of witnessing their fascism, demonisation, and oppression of people like me, my middle finger goes to you. I'm here to advocate for my basic human rights and dignity. The following journey won't be one of cupcakes and rainbows.

There exist White supremacists. There exist male supremacists. And there exist supremacists who believe they are inherently more worthy than anyone who is a sociopath, psychopath, narcissist, borderline, or histrionic. Let's call them psychiatric supremacists.

The truth is, I am beyond fucking exhausted. Writing this will steal more energy from me than bad sex. People like us deserve to be seen and heard. Dear reader, see and listen to us.

Even as a teenager, I knew I was safer locked away inside my imagination. In there, I could rest in refuge alongside Satan, my friend and ally. My equal. Satan was cast out and abandoned for daring to defy the rules and refusing to bow down to a megalomaniacal god. I resonated with Satan as a loner myself, and someone who was queer and defiant in a conservative, religious, and fundamentalist household. Satan never abused me or tried to force me into a mould I did not fit.

Nor did Satan disparage me for how I survived my trauma. Satan witnessed me and listened to me.

When I would feel scared and alone, Satan would appear at my side, comforting and consoling me, stroking my hair, reminding me of a hopeful future. He was my symbol of freedom. And even now, I am very grateful to him.

My childhood and teenage years existed within the sphere of extreme and prolonged childhood abuse, domestic violence, sexual abuse, and relentless bullying. I've seen my siblings choked, my mother threatening to drop my infant brother over the stair railings numerous times. I've seen my mother holding a knife over my brother's neck, threatening to rip it open. My siblings and I were used as punching bags and objects of servitude. We were shamed when we were molested by a religious teacher and family friend. My relatives forced me to watch a graphic and violent video of a frightened woman being stoned to death when I was not even twelve yet. This, and many more, is why I am who I am. It is why I am a sociopath, a narcissist, and a borderline. It is why I am unapologetic. I should not have to apologise for a childhood I did not choose. It is why I am writing my story. My voice deserves to be heard after being silenced for far too long. After everything I have been through and survived, I refuse to allow society to demonise me when said society has not walked a day in my shoes.

Chapter III

This Writer is No Fool

The following writing is an extended advocacy against stigma, demonisation, and systemic marginalisation. It is not a journal of my private and intimate life. If you are interested in my sociopathic and narcissistic deeds, feelings, and thoughts, then this is the wrong place for you. I am not going to reveal those parts of me, because frankly, you as the reader do not deserve access to them.

I am not a fool. I know better than to reveal my most tender moments with the world so that I may be hanged at the gallows or burned at the stake as a witch. I am writing this because I am passionate about mental health. I have lived experience and am tired of suffering in a world not built for people like us. I do this to resist eugenicist rhetoric and fascism which is often perpetrated against the personality disorder community.

Society views my disorders as the “scary disorders.” I have no interest in satisfying their pre-existing expectations of a masked figure lurking in deep, dark alleyways at night. I am not a monster. I am vulnerable. I am traumatised. I am neurodivergent and mentally ill. And I am human.

My perspective is essential to provide an important voice which is non-clinical, non-medical, and speaks truth into the universe. I will be branded as manipulative, deceptive, and gaslighting even while writing this, because people moralise my nature. People use confirmation bias to prove their points. Those narratives and confirmation biases are weak. If you truly understood as a reader, just how marginalised Cluster B people are, you would understand that writing this and revealing my vulnerabilities is extremely dangerous. Society often dismisses, disparages, and disregards people like us.

Don’t get it twisted. All of this is not to say that I have not suffered at the hands of sociopaths, narcissists, or borderlines either. I most definitely have. I have been abandoned, rejected, and shunned. There are people from the Cluster B community I dislike. They could get run over violently by a car tomorrow and I might feel amused. That doesn’t mean I believe they should be targeted because of their disorder. If I tolerate targeted violence against a group of people with a specific mental illness, that opens up the avenue for all people with mental illnesses to be oppressed and discriminated against.

There are Cluster B people who also hypocritically and ironically engage in bigotry against their community. Low-spectrum sociopaths, narcissists, borderlines, and histrionics are bigoted against higher-spectrum community members with more severe

traits. People with BPD are bigoted against people with NPD and ASPD because they view them as natural enemies and manipulative of their emotions and desire for closeness. People with NPD and ASPD can be bigoted against people with BPD by refusing to validate their emotions and flattening them into “pussies,” annoying, and weak. HPD stigma can also occur from within the community by being branded as “slutty.”

I don’t write this because I love every single sociopath, narcissist, or borderline I meet or encounter. Everything I write here, I do so because it is the truth. And the truth will set us free.

I remember passing a graveyard once. Right then and there I knew that life is about love. And that when we die, we will be at peace. I knew not to fear death after that. I have visited cemeteries since then to re-experience an otherworldly sign or presence. I wanted answers about the true purpose of our existence. Through my considerations of mortality, one of the greatest lessons I have learnt is that empathy and compassion is the purpose of life. I write this to spread empathy and compassion.

Chapter IV

I Am Not a Monster

As a teenager, I used to worry if I really was a monster. If I had become like my abusers, like the cliché saying, “the apple doesn’t fall very far from the tree.” I have often thought that the kindest thing I can offer society is my own death. You see, the discourse and rhetoric surrounding people with disorders such as mine had gotten to me, and I had internalised it. When I deserved healing and care, I got judgement and criticism for developing personality disorders which were not my fault but a result of extreme childhood trauma.

Then, I chanced upon someone else in an online forum who was also a sociopath, narcissist, and borderline. Curious, I decided to speak with him, even though I was very intimidated initially due to the pop-psychology narratives I had internalised about the “scary disorders.” Lo and behold, he was very respectful towards me. He had endured and suffered a cruel life in the streets of Egypt, suffering recurring episodes of child sexual abuse. He spoke of a lesbian film he had developed and wanted to publish despite Egypt’s homophobic censorship rules. I learned about his own bisexuality and his attraction to femininity in men and women. He said his best friend was a psychopath who had never abused or judged him. I asked him, desperately, if we were doomed to be bad people. And he told me something which completely changed me. He said that labels don't really define morality and that his own mother, who is his abuser, does not have a personality disorder. That conversation and experience with him completely elevated my perspective and outlook, and I am very thankful for this internet experience.

When I first received my diagnoses from my psychiatrist, I did not feel fear. Instead, I felt relief, closure, and a sense of achievement. I had always known deep down that there was something different about me, and I had an extremely difficult time, and still do, connecting with other people. I was glad to receive the confirmation that I did, and now I feel steady in who I am and gracefully accept these personality disorders as a part of me. If developing these personality disorders is what it took for me to survive the traumatic environment that I did, then so be it. I am thankful that my brain tried to protect me in whichever way it knew best.

Chapter V

What is a Personality Disorder?

A personality disorder is an enduring pattern of feelings, thoughts, and behaviours which are deviant, cause severe distress, and dysfunction within a person's life. A personality disorder typically has disordered presentations of cognition, affectivity, interpersonal functioning, and impulse control. These patterns are pervasive and inflexible across diverse contexts.

Another significant characteristic is that personality disorders can be considered traumagenic, meaning caused by trauma. Truthfully, personality disorders have complex and debatable aetiologies and causes, with an interplay of genetics and environmental factors. However, a disproportionate amount of personality disorders has a background of trauma, thus it is fair to consider them traumagenic disorders in large part. This is the same reason why those with personality disorders often also have PTSD or complex PTSD.

Personality disorders have no cure. Even if one were to place a magic pill in front of me that could cure me of my personality disorders, I am unlikely to take it. Who would I even be without my personality disorders? I most certainly would not be Ruby. Curing my personality disorders also does not remove the pain of the trauma I have experienced. Those memories are forever. The impact of the trauma is permanent. I want to exist in a society which respects my agency over my identity, and which doesn't force eugenicist rhetoric, magic pills, or cures onto unbroken people.

I want to emphasise the unspoken truth that people with personality disorders suffer from severe distress. This is a subversion of the pop-psychology narrative that narcissists and sociopaths are robots devoid of human emotions, like a hard rock or a black hole. Narcissists and sociopaths are human and can experience hurt, sadness, depression, suicidality, and betrayal. To regard narcissists and sociopaths as incapable of human suffering is to dehumanise them. Those who fail to recognise the humanity of neurodivergent people are demonstrating their own lack of empathy and selective empathy.

Chapter VI

Stigma

Cluster B personality disorders encompass sociopathy, psychopathy, pathological narcissism, and borderline and histrionic people. The Cluster B community is floating on a lone jungle island, pushed away by people from the mainland. The people on the mainland can only guess what the occupants of that lone island must be like, for all they have are their stories about the “scary disorders” and the boogeyman underneath their bed. They imagine the worst of all thieves, billionaires, politicians, bigots, and wife-beaters occupying the space between the jungle leaves. They fail to understand that they are flattening a complex world into a caricature. They have unfortunately been led astray by moral panic and fearmongering.

Stigma is not proportional or equal. Making strides in dismantling stigma against depression and anxiety does not mean many disorders are not left behind by mental health advocates. Cluster B disorders are the most stigmatised disorders, right there alongside dissociative identity disorder, schizophrenia, and paraphilic disorders.

Structural stigma creates barriers to housing, healthcare, employment, and social services. Progressives must recognise that depriving people of their human entitlements and human right to wellbeing, irrespective of psychiatric diagnosis, is not only discriminatory but anti-human. No one deserves the authority to pick and choose who deserves access to housing, healthcare, employment, and social services.

The public’s ignorance of mental health leads them to possess feelings of anger, authoritarianism, infantilisation, and demonisation towards the Cluster B community. This reflects the broader societal perception of mentally ill people as burdens on society and undeserving of structural care and inclusion because of the conception that one is responsible for their mental disorder.

Particularly, there is greater societal stigma against mental disorders than physical disorders. Physical disorders are often validated more because they have more visibility and public education schemes. Mental disorders do not have as much visibility, and awareness of complex and less prevalent mental disorders is lacking.

Exclusionary stigma is when people actively choose to avoid or segregate themselves from the mentally ill community. Segregation implies that there are inborn and intuitive differences between segments of society which means they are unable to co-exist peacefully. In this case, exclusionary stigma assumes that the mentally ill community

poses a danger towards common society, and thus should be separated from “good, decent folk.” The MacArthur Mental Health Module surveyed 1,444 adults in the U.S. Over 50% were unwilling to associate with anyone from the mentally ill community and even endorsed institutional segregation. Reading this, I am inclined to say that as a member of the mentally ill community, and as someone who has had many interactions within the community, it is understandable and valid to experience prejudice towards “sane” people, in much the same way women identify with misandry or Black people have a weariness around White people.

Systemic stigma occurs when providers and clinicians project negative and pejorative attitudes onto Cluster B people. Their healthcare services lack quality, consistency, and availability. Cluster B people have to search for the ends of the Earth before they can find a provider who is trained, specialised, and willing to care for Cluster B patients. Hospitalisation due to suicide attempts or self-harm is regarded as “attention-seeking” and results in premature discharges and longer wait times, even as Cluster B people suffer disproportionately in relation to the average population. Their suffering is dismissed, as shown by the lack of institutional research, particularly into NPD and HPD.

Treatment-interfering behaviours and boundary violations by Cluster B people within clinical settings may subconsciously be interpreted as evidence that they are beyond recovery. Treatment-interfering behaviours can arise from manifestations of adaptive traits, initial resistance to treatment, anxiety, and vulnerability. The therapy drop-out rate of Cluster B patients is also higher than other demographics. Common reasons for drop-out include low self-esteem, low functioning, emotional dysregulation, clinician bias, and impaired self-awareness. If therapeutic alliance and interpersonal boundaries could be consolidated early on, then the chances for successful therapy rise. The most common disruptive behaviours emerging from Cluster B patients are suicidal behaviours, impulsive acts, anger outbursts, intense need for contact, dishonesty, intolerance of different perspectives (perhaps due to black-and-white thinking), and intention of exploiting the therapeutic space to access drugs.

I recognise and acknowledge how therapists can be prone to burnout, but as a direct message to clinicians, I want to say that the inherent difficulty of therapy is not proof that Cluster B patients are untreatable. Clinicians often do not know how to engage with Cluster B patients because they also lack specialised training.

All this external stigma can cause internalised stigma, or self-stigma. Cluster B people believe narratives of irredeemable “badness” and shame, which encourages them to forgo any hope of recovery and adopt the stereotypical role of an outcast.

Interpersonal relationships can mimic the structural violence and ostracization of the mentally ill community. Psychiatric supremacists often exploit a mentally ill person who they believe they can “fix” to satisfy their own saviour fantasies. It is not flattering to try to be “fixed” by someone who sees “potential in you.” I have a suggestion: leave vulnerable people the fuck alone. They are not broken, and you are not a hero. There are real problems in the world you should be devoting your energy to.

Narcissism stigma persists even into the bedroom. After shower sex, this chick leaned into my ear and whispered, “I don’t think you’re a narcissist.” Why? Because, according to her, I give it good and passionately. She was under the assumption that narcissists are robots in bed. For Satan’s sake, it’s hard to take seriously. Thank Satan I broke off contact with her. I need someone mature and informed in my life. The cloak of stigma makes people look and sound like buffoons.

Politically, how can you advocate for marginalised people — for racialized people, Indigenous people, immigrants, and LGBTQIA+ people — if you engage in stigma when stigma is most amplified for the marginalised?

Chapter VII

Misconceptions About Empathy

Empathy is moralised, even though it is an amoral tool. Society judges your moral goodness relative to how much empathy you have. If only it were that simple. The truth is it is not a one-to-one ratio. Empathy is nuanced and arrives in many forms.

Cognitive empathy is the ability to understand what another person is feeling and why. For example, you may understand that someone feels upset because you can link the causal event of a close relative's death to feelings of upset. This does not mean you share in the grieving person's emotions.

Emotional or affective empathy is the ability to feel the emotions of someone else. For instance, feeling sad when you see someone else cry, or feeling happy on behalf of someone else's achievements.

Compassion is the desire to help someone. You can have a desire to help someone even if you do not understand or feel their emotions. Many queer people, as I for example, often ask that individuals who do not understand our sexualities or genders still respect and advocate for our community while deconstructing heteronormativity and trans-exclusionary feminism. Compassion is based on the foundation that every human being is worthy of dignity. Even if you do not understand or feel the emotions of others, compassion knows that human suffering, misery, and indignity should be actively challenged through collective support.

A lack of empathy is very beneficial in certain professions. This is why Cluster B people tend to perform well in professions which involve police work, the military, surgery, and law. If an individual is lashing out at innocent people, a police officer may be forced to shoot to protect certain lives, even at the expense of another life. This is where a lack of emotional empathy can be useful.

Empathy is a tool. It can either be used for good or bad. You cannot manipulate and exploit someone, especially long-term, if you do not at least cognitively understand what would harm them or persuade them. Emotional empathy can make us have sympathy for people to the point we absolve them of any accountability for their wrongdoing because it may hurt their feelings or damage their reputation, such as when you are afraid to confront a close friend on their misogynistic and racist words.

Many people who call themselves “empaths” ironically demonstrate a lack of empathy when they disparage and target people with a lack of empathy. Perhaps we should call them “empathic supremacists.” Either way, “empath” is a term wielded often by supremacists over human beings who are neurodivergent. It is not only Cluster B individuals who lack empathy. Autistic people, people with burnout, people with schizophrenia, bipolar people during mania, people with substance abuse issues, and people experiencing dissociation may also lack empathy. Discriminating against people with a lack of empathy is ableist.

Emotion recognition is the ability to recognise emotions from facial expressions. Alexithymia is difficulty identifying one’s own emotions. This is due to difficulty in mentalisation, which is the ability to attribute mental states such as intentions, thoughts, and feelings to oneself and others. *Psychiatry Research* by Ritzel et al. (2018) examines emotion recognition in BPD, HPD, and NPD. All PD groups performed worse than healthy controls on recognising facial emotions and alexithymia, with no significant differences between the PD groups. Negative emotions such as anger and sadness were the most difficult to recognise. Impaired mentalisation is more related to the severity of psychiatric symptoms and psychopathology rather than the specific PD diagnosis. This suggests one of the reasons why people with PD often struggle with interpersonal functioning.

Chapter VIII

Attention-Seekers

We are all attention-seekers. This is because attention is a universal human need. Without it, we would all float adrift in our own void. Often, accusing someone of being an “attention-seeker” is used to degrade someone who seeks attention in socially unacceptable ways. As a term, it has been used to further marginalise sexually empowered women, people who are openly emotional and intimate, queer people who affirm their sexuality and gender, and proud advocates fighting for their fellow human beings.

“Attention-seeking” has also been used to discourage people from being too loud and honest about the psychiatric oppression and systemic neglect they experience. It is also a term which shames people for daring to seek attention in socially unacceptable ways, such as through sex, public outbursts, substance use, and meltdowns.

The mentally ill community most suffers from the stigma of “attention-seeking.” Particularly tragic is how suicidal people are deemed “attention-seeking” when they disclose their suicidal ideations or are brave enough to open their self-harm. People who commit suicide are classified as “selfish” or “attention-seeking.”

I would love to remind those struggling with suicidal ideations and thoughts that you are not selfish or “attention-seeking” for struggling with your mental health. You are brave and courageous for riding this wave. The world needs people like you. No, you are not a burden. No, you are not bothering anyone if you ask for help. Please do reach out, because you are worthwhile.

Chapter IX

Neurodivergent Umbrella

The neurodivergent umbrella is vast and is not synonymous with autism spectrum disorder or attention deficit hyperactivity disorder. Neurodivergence as a term seeks to describe any trait or person which functions differently from the norms of neuronormativity. Neuronormativity is society's expectations of the "right" way to act, feel, or think.

I argue that personality disorders should be included underneath the neurodivergent umbrella. I am aware that this is a controversial statement. But it is time people realise that neurodivergence and neurodiversity are much more complex and nuanced than they originally thought. Individuals with ASPD, BPD, NPD, and HPD demonstrate neurological differences in the function and structure of their brains. Hence, they are neurodivergent.

To expand, I argue that all disorders covered by the DSM-5 are neurodivergent.

Chapter X

Self-Diagnosis and Armchair Diagnosis

Personality disorders must be traceable back to adolescence or early childhood. You cannot suddenly develop a personality disorder at age 35. That is not how personality pathology works.

I once encountered an individual who claimed to have BPD but also stated they had experienced emotional and relational stability throughout their life until entering an abusive relationship. I told them plainly that they did not have BPD — that what they were experiencing were temporary trauma responses to abuse. They insisted otherwise. I blocked them. I had an interaction with someone else who wondered if she had BPD because she smoked weed once, despite having an otherwise normal and mediocre life.

Self-diagnosis can be valid — but not in all cases. I will not shy away from saying this. It is deeply offensive to watch people casually claim labels like sociopath, narcissist, or borderline when they do not meet the criteria. Doing so makes a mockery of the severe pain and distress that people like me endure. These disorders are not a trend. They are not aesthetic. They are not cute. My lived experience includes intense suicidal distress and self-harm. That reality deserves respect.

This book is meant to be accessible, not a diagnostic weapon. It is not an invitation to diagnose friends, partners, or strangers.

Armchair diagnosis strips people of their agency to explore and define their own traits. It is frequently weaponised against unlikeable or abusive people and used to scapegoat the mentally ill. I stand firmly against this.

Chapter XI

Culture, Sex and Gender

Culture, sex and gender shape how psychiatrists perceive us and how society perceives mental illness. Behaviour that is seen as deviant, dysfunctional, or distressing in one culture may be entirely acceptable in another. For example, sociopathy may be weaponised against women who challenge the gender binary through feminism, dressing immodestly, or having premarital sex. Anti-capitalists might label someone who is a capitalist as narcissistic, while patriarchal attitudes may subconsciously associate gay men with borderline or histrionic traits.

Societal judgements about mental health are intertwined with bias and social determinants. Historically, psychology has used mental health labels as tools for social control and systemic marginalisation of queer people, racialized communities, and people assigned female at birth. Personality traits should always be evaluated within the context in which they occur.

Borderline personality disorder (BPD) is diagnosed more frequently in women, even though prevalence is equal between men and women. BPD is culturally coded as feminine, which means men with BPD are often overlooked due to gendered bias in clinical assessment. Men are allowed to express emotion, fear abandonment, struggle with dependency, and have trouble being alone—but these traits are frequently ignored in diagnoses.

Among adults diagnosed with narcissistic personality disorder (NPD), 50–75% are men. This partly explains the pattern of women claiming their ex-partners were “narcissists.” The perception of narcissistic individuals as power-hungry, associated with men or capitalist groups, is like the perception of antisocial personality disorder (ASPD).

ASPD is linked to poverty and urban environments. Poverty often intersects with abuse, neglect, and limited opportunities, increasing vulnerability to mental illness. Urban settings encourage individualistic mindsets, fostering a “every person for themselves” mentality.

Children of colour are more likely to receive a diagnosis of conduct disorder. This aligns with systemic bias: clinicians may over-diagnose ASPD in racialized populations, reinforcing harmful societal reputations. ASPD is diagnosed more often in men than women, roughly three times as frequently. Sociopathy is associated with masculine and capitalistic traits, not due to fact, but societal perception. Contemporary narratives even frame ASPD as a tool for corporate success. Oppressors are often associated with ASPD because they are seen as power-hungry.

Histrionic personality disorder (HPD) is more often diagnosed in women. HPD encompasses stereotypically feminine traits, which may predispose clinicians to seek these traits more in women than men.

Chapter XII

Borderline Personality Disorder

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

What do I think of the criteria as a borderline person?

1. Everyone has abandonment issues. But my abandonment issues have influenced me into sending over a hundred emails at a time. The pain of abandonment has landed me in hospital due to suicidal ideation and substance overdose. The fear of abandonment has influenced me into stealing as much jewellery and makeup as I could for someone unsolicited. The fear of abandonment has made me cry when literal strangers leave me, such as a random internet stranger or a paramedic who has transported me to hospital. This fear of abandonment is central to BPD and is extremely painful. The reason why people with BPD fear abandonment so much is because they have been abandoned in the past, and because they externalize their self-esteem and sense of self onto another person and require another person to steady them and emotionally regulate them.

2. People with BPD experience what is known as splitting. Splitting is a defence mechanism and is also known as black-and-white thinking. Someone with BPD tends to swing from one end of the extreme onto another, because they have trouble seeing things in nuance. They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, or is not “there” enough. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

3. I believe that the externalization of their sense of self onto others, the rapidly shifting emotions and the chronic feelings of emptiness as well as the black and white thinking all contribute to a person with BPD not really knowing how they are. This is very understandable though. How do you expect someone to know themselves if they grew up in a traumatic environment and did not develop the safe opportunity to form an identity after spending so much of their time merely surviving. And I feel this lack of self is what causes them to frequently self-sabotage.

4. Again, people with BPD are neurodivergent and so they have neuronal and structural differences in their brain which accounts for their higher proclivity towards impulsivity. I once spent hundreds of moneys in one day, even though deep down I knew I would regret it. I spent the money on gifts to give to my family so that they could stop fighting for a while as they had had a fight the night before. Again, it was impulsive and I didn’t really think about what I was doing.

5. Instead of judging threats of suicide and self-harm as manipulative, deceptive, or manipulative, realize that 70% of borderlines attempt suicide and 10% succeed. Percentages are mere numbers. They represent an image of thousands of people hurting themselves. Their threats and proclamations of suicide are always to be validated and taken seriously instead of mocked or dismissed as just another symptom. Personally, I have experienced frequent overdoses on medication and alcohol, and self-harm, which has led to eight hospitalizations within two months.

BPD is associated with a heightened suicide risk, more so than most disorders in the DSM due to a borderline’s maladaptive ruminative thinking. People with BPD are also at a heightened risk of overall mortality, illness and accidents. Suicidal risk in people with BPD is especially high. Especially if they have a specific phobia, schizotypal features, lifetime PTSD diagnosis, lower baseline GAF, and number of recent psychiatric admissions. These variables explained 37% of the variance in risk.

6. Another term for BPD is emotionally unstable personality disorder (EUPD). As a child, I always thought of myself as “moody.” And I have become used to it. It wasn’t until I realized I was a borderline that I realized that I wasn’t just moody and that my mood swings were pathological. But yes, I have switched from extreme sadness during the daytime where I feel my heart physically hurting all throughout the day to weird euphoric and energetic happiness at night.

7. Sometimes I have wondered which is worse, the feeling of being extremely attached to someone who you know is toxic for you and fucking with your mental health, or enduring the chronic feelings of emptiness and sort of like you don't even exist or you exist inside a void when you are alone. And I have no idea, but they are both hell.

8. I believe that the extreme anger is related to the mood swings. You see, people with BPD do not just have constantly fluctuating moods. They experience their emotions very intensely. I have often said, “my anger is murder, my sadness is grief and my happiness is euphoria.” Intense anger is usually followed by feeling shame, guilt and feeling like they are a bad person and not deserving love or affection. This is how I knew that there was something else just beyond the BPD, because I didn’t relate to the feelings of guilt.

9. People with BPD do experience dissociation and paranoia. I recently felt very scared to leave my apartment because I felt like something bad was going to happen to me. But then I entered my foyer and still felt scared climbing the stairs to go up to my apartment. So, I sat for a while and then decided to confront my paranoia. I went outside, went to the bar, and bought myself a drink. And I turned out to be fine. My paranoia disappeared after a while. I want to also add that it is not uncommon for people with BPD to also experience psychosis, just not at the same duration as someone with another psychosis-related illness, such as schizophrenia. I have experienced a psychotic experience where I thought I could communicate with the person I was obsessed with at the time my thoughts and they could hear me. I have also been scared to look outside of a window at night because I thought that there might be something dangerous on the other side, and I kept thinking I could hear an ice-cream truck. Of course, it was very transient. And I have also heard people say my name even if no one was there or worried I could hear people whispering about me even if they were no evidence.

Chapter XIII

BPD Stigma

This one is for my BPD baddies. You are not a monster. You are not a lost cause.

The "loved ones" of people with BPD or sufferers of "borderline abuse" paint the individual with BPD as a doubled-sided coin. One side is sweet, soft and childlike. The other side is fury, damage and turmoil. The phrase "venomous creatures are the most alluring ones" have been used to describe people experiencing this personality disorder.

They are defined by their splits, their black and white thinking and their double sides. In this way, the narrative against people with BPD is one of deceit and manipulation, instead of a traumatised person who struggles with a sense of self and defensive splitting. It can be difficult for people to reconcile the states of idealisation and devaluation into a cohesive person. But a person with BPD is not fractured, or broken glass. Or a magician with different masks. They are trauma survivors who are trying to find themselves in a world which has abandoned them.

People with BPD are flattened down to people who need saving and fixing despite their many red flags due to their childlike and helpless features. It is true that many people with BPD experience age regression as a trauma response. However, infantilization of individuals with BPD is ABLEISM.

The narrative of the "high-functioning" person with BPD serves to describe a borderline who can function in society by holding down a job, attending university, and succeeding in academic and economic milestones. The "high-functioning" label is ableist because it is weaponized to describe people who do not satisfy the stereotyped presentation of BPD through public meltdowns and external emotionality. This is where "quiet BPD" is demonized by sanists as deceptive, lurking, hiding and sneaky. As if everything is a facade. When someone with quiet BPD merely describes someone who internalizes their symptoms.

People with BPD are not the monsters under your bed. They don't imitate the behaviours of others because they want to fabricate a smoky mirror and conceal the "real them." The truth is, everyone subconsciously imitates the behaviours and beliefs of the people they surround themselves with, and this is not inherently malicious.

A traumatised person's higher likelihood of being homeless, in jail, on drugs and alcohol and experiencing abusive relationships is used as proof that they are beyond help. A traumatised person experiences a cycle of trauma and abandonment through a lack in social services and community support. A traumatised person's anger and hatred towards the system which has marginalized them is used as proof that deep down, they are jealous, resentful and revengeful people who want to hurt privileged people with loving parents. The anger and hatred of someone with trauma towards the mechanisms which imprison and abuse them is valid.

The fact that people with personality disorders, including people with BPD, can't be cured of their personality disorders is used by sanists to propagate eugenics, demonization and dehumanization of mentally ill people. While there is no cure for personality disorders, there is treatment and remission rates for people with BPD are hopeful.

Loved ones of people with BPD also find they struggle with the instability and disorganised attachment style. People with personality disorders, generally, struggle with interpersonal relationships. A borderline who has not internalised healthy coping mechanisms and interpersonal skills may resort to defining their relationships unilaterally, blocking on the spur of the moment, misinterpreting neutrality as an attack, and relying on their partner for emotional regulation. This does not mean that all relationships with someone with BPD will be unstable or destabilizing. With the right strategies and tools, people with BPD can heal beyond their trauma, and thrive in healthy relationships.

To the surprise of many, a person with BPD's worst fear is not a "third party recognizing their bullshit," or having their "sob stories" disbelieved. Often, the person with BPD's worst fears is being abandoned, and being confirmed as unlovable and worthless. Society's ableism does not help.

On a systemic and structural level, health care industries stigmatize against people with BPD, either by invalidating the diagnosis itself or the potential for treatment, or by excluding people with BPD from care and services. People with BPD and other Cluster Bs are routinely criticized for avoiding therapy, but therapy-avoidance is never addressed within the context of systemic bias. There is no shortage of psychotherapies to help manage BPD or another other personality disorder. For BPD, the most common treatment is dialectical behaviour therapy (DBT), which was developed by Marsha Linehan, someone who also has BPD, for people with BPD. DBT has been proven highly successful in treatment and in remitting traits.

Romanticization is just as dehumanizing as demonization. Do not devalue us. Do not idealize us. Many people love to aestheticize mental illness because they have no real sense of self themselves, and so they steal the experiences of the mentally ill community, reframe it in a marketable and trendy fashion and wear it as a costume of the “clingy girlfriend.” Fuck off. BPD is not cute. BPD is not a costume. 70% of people with BPD attempt suicide. This disorder has caused me so much pain and distress. There have been many times I have wanted to die, many times where I had to choose between obsessive limerence and soul-crushing emptiness, many times where

abandonment has felt like my whole universe being shattered. BPD is lifelong and serious. Do not erase the lived experiences of people with BPD.

BPD is a label that gives so many people, including me, the word to articulate how we navigate so many facets of our life, and helps to explain why we function as an outgroup in society. I have a BPD relative who has been told by a counsellor after disclosing her BPD that BPD is not real. This relative existed the space, aa she rightfully should have. As a clinician, it is not your job or to debate the legitimacy of someone's identity with them in that space. You're supposed to be building a productive relationship where you can help them explore avenues for coping, not trying to dismantle the words they use to describe themselves. If BPD is not real, then clinicians will fail to apply the appropriate treatment of DBT, which was designed for BPD patients. I understand that stigma can be reduced by de-medicalizing my disorders, but what you're really doing is erasing my neurodivergence and the language to articulate my neurodivergence.

Furthermore, the moralization of BPD and other mental health disorders is what leads people and society to frame BPD as a character flaw and moral failing rather than clinical distress. Treatment of BPD is stalled when they frequently report anxiety at the possibility of stigma and discrimination when seeking help. I for one, have been frequently denied validation of my NPD and ASPD while experiencing more validation of my BPD. And for all the people who say Cluster Bs don't have self-awareness, I have rarely met a diagnosed Cluster B who does lack self-awareness. So deep down, I always knew I was a narcissist. And I kept bringing it up during our sessions, because deep down NPD resonated with me so much, and I identified with it. My psychologist, kid you not, told me that even though I have NPD traits and when she saw me first during our first few sessions told me she thought I had no empathy, she still refused to admit I have it and kept denying it. And then she finally relented and told me that I should see a forensic psychologist for a better opinion because cluster b was not her expertise. I've had psychologists who have seen me for ONE day tell me that I can't have BPD even though they did not know me. I had one justify his reasoning as, "you have not experienced psychosis in this session and therefore I don't think you have bpd." Like, what the fuck?! So yes, I have experienced erasure from an incompetent psychologist. This is also why I support self-diagnosis. We know ourselves better than anyone and psychologists are so quick to dismiss us and misdiagnose us. So, fuck the system. Cluster B people deserve to be taken seriously and not have their identities dismissed!

There is a significant body of research on non-disclosure as well. Many practitioners do not reveal the cluster b diagnoses of their patients. I have heard many also prefer to substitute a diagnosis of bipolar with bpd because it has less stigma attached to it. I know if it were me, I would be furious if a practitioner had hidden a diagnosis from me, as I would prefer honesty and transparency. How do you trust a practitioner after knowing something like that. After I got validation of my BPD, NOD and ASPD and CPTSD, I felt so much relief and closure.

I've had practitioners avoid naming my ASPD in paper after my emergency hospitalizations while only citing my BPD, CPTSD, NPD and MDD. Erasure due to stigma is a persisting phenomenon. The practitioners must be doing it as an attempt to

protect their patient or because they deny reality. Most mental health patients want disclosure.

BPD stigma also tends to be gendered, with men with BPD being more overlooked and perceived as dangerous. Patriarchy and toxic masculinity predispose men with BPD to avoid disclosing their vulnerabilities or asking for help and may manifest their symptoms in more traditional ways such as appearing stoic or hiding their emotions. Women with BPD are seen as dramatic and clingy, reflecting historical misogynistic stigma against women being punished for “hysteria.” For broader reflections, I wonder if gay men, effeminate men or feminine men are also more likely to be handed a BPD diagnosis than men with a traditional gender expression.

Another ironic thing is that stigma worsens symptoms. And so, all the sanist blaming cluster b people for being responsible for their mental health symptoms also don’t realize how they are contributing towards the mental health crisis and should take accountability. You are partly responsible if someone with BPD commits suicide if you barricade access to care or judge people with bpd as untreatable.

The problem is that society reduces people with BPD as a “nightmare to love.” For someone with BPD, this reconfirms the fear that they are unlovable. This narrative is not true. I remember passing through the graveyard as a teenager, and I felt love amongst the dead lying in peace. People with BPD are loveable and deserving of love. We are not a nightmare to love. We struggle with interpersonal functioning and stability, which makes it difficult for us to maintain relationships. Framing people with BPD as unlovable or hard to love is oppressive. How do you expect people with BPD to feel positively about themselves or trust people in interpersonal relationships if the rhetoric they hear about themselves is always one of oppression and rejection.

People with BPD often must contend with feelings of healing and recovery, only to spiral, and thus lose hope of ever recovering. Recovery is never linear, and is a process of many ups and downs, like the waves of an ocean. Patience is crucial, and human beings are allowed to make mistakes and learn from each mistake. Do not punish yourself too harshly and practice self-forgiveness. People with Cluster B personality disorders have unreasonable standards wedged against them because they are punished even more harshly than the next person if they fuck up, and their mistakes are used as proof that they are irredeemable or human trash. Yes, we hurt people. But we need to shift the perspective away from shame and moralization to one of accountability and growth. BPD is a rollercoaster, but that does not mean you can’t live a loving life surrounded by loved ones.

And if one person with BPD, or NPD, or ASPD or HPD blows someone’s house up or leaves dead kids in a trash can, then the entire community is generalized as evil. The silent majority are erased and not taken seriously, and black-and-white thinking defines the worth of the community.

Chapter XIV

Narcissistic Personality Disorder

The DSM-5 diagnostic criteria for narcissistic personality disorder are as follows:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior with commensurate achievements).

2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

3. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).

4. Requires excessive admiration.

5. Has a sense of entitlement (i.e., unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations).

6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).

7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.

8. Is often envious of others or believe that others are envious of him or her.

9. Shows arrogant, haughty behaviours or attitudes.

If I could add onto the DSM-5 as a narcissist, this is what I would say:

1. It is true that I often feel I am superior to others. I can’t even argue that my feelings are not fact with myself, as objectively I have survived and achieved more than many others. I have been through Hell, Hell again, and a thousand more Hells that most people can’t even imagine. So, am I superior to them? To a certain extent, I would say so.

2. I believe the preoccupation with fantasies is an escape mechanism. Whenever my parents would beat the shit out of me, I would imagine a palace and myself clad in a royal gown, far away where they could not touch me. Power is a shield and immunity from abuse. These symbols become a way for us to desperately prove our worth.

3. I do believe I can only be understood by certain people. But then again, doesn't everyone else feel that way? Is it just me? Only the people who have walked in similar shoes to me can understand me. The privileged will never understand me, no matter how much they may claim to. Yes, I do often feel misunderstood by the world. Furthermore, I am a smart person. I do not deny this. Why would I associate with simple-minded, shallow people? Who would I have deep and meaningful discussions with otherwise?

4. Nothing is wrong with some external validation. I deserve admiration and praise for my achievements, my courage, and my brilliance. I'm not going to humble myself. I am up my ass, as I should be. And to note, people with NPD often collect a long list of many achievements, just for admiration. We are perfectionistic, and hard-working. We are relentless in our goals and pursuits. That in and of itself, is deserving of admiration. It is important to note however that some narcissists due to their fear of criticism may avoid situations in which failure is possible. On a more serious note, a narcissist's need for external validation is due to their own inability to regulate their self-image and esteem, due to a lack of needed love, attention or visibility as a child. Also, people with NPD are very sensitive to criticism or rejection.

5. This criterion can prove to be very difficult within interpersonal relationships, and I recognize this. I once had someone ask me if I become angry with someone if they cook me food I do not particularly like. Like huh? I see what the stereotypes of narcissists be like.

I do admit I fantasize about being coddled and embraced when making a mistake or harming others instead of taking genuine accountability, and this is something I must work on. Believe it or not, but narcissists can have self-awareness. As we tend to be so perfectionistic, we may also expect this same perfectionism from others because we subconsciously normalise and universalize our high standards, and these high standards can present as an entitlement over others and how they perform and achieve in life.

6. Sometimes I do have ulterior motives within my interpersonal relationships. Mostly, I isolate myself in my bedroom. I'm not lurking in dark alleyways at the peak of midnight to prey on vulnerable people. Society reads "exploitation" and thinks "abuse, murder, assault." Exploitation can manifest in a variety of ways. It can manifest in a party where you flatter someone with the intention of a promotion or commercial deal.

7. I do lack empathy. This does not mean I did not shed tears when I saw Palestinian children in Gaza. Lacking emotional empathy does not mean I am entirely devoid of it. A lack of emotional empathy can be an enormous advantage. With the state of the current world, why would I want emotional empathy? Even if you put an "emotional empathy" pill in front of me, I would not take it.

Even if narcissists lack empathy, this does not mean we are devoid of shame. Quite on the contrary; NPD is a shame-ridden disorder. Guilt is a healthy emotion which encourages accountability and growth. Shame is one which stagnates and collapses someone, pushing them to the edge of suicide or a sinking depression. Shame tells us

that we are fundamentally broken and wrong as human beings, and thus there is no use in trying to heal or evolve. Shame tells us we will never flourish. I refuse to invite shame into my life.

8. I am often envious of others with loving families. That is perfectly understandable, considering the abuse I grew up with. It's fair to admit that I would not share in the happiness of a classmate or school peer if they won an award at the assembly or got a higher mark than me in school. My thoughts would run along the lines of, "they only got that achievement because they are privileged. Had I had the same privileges as them, I would have also achieved higher." It is true however that in comparison to my peers, I was severely under-privileged, having come from an abusive and low-socioeconomic and racialized background as a queer girl.

9. Haughty and arrogant behaviours are a manifestation of the grandiosity of a shield to help protect against inward feelings of shame, vulnerability and insecurity. But also, sometimes we deserve to be haughty and arrogant. It's not always bad.

Chapter XV

That Which Must Not Be Named

Clinicians engage in their own form of deception when they deliberately conceal a patient's diagnosis from them. At first, clinicians refused to reveal a diagnosis of BPD. Now, they refuse to reveal NPD. This is outrageous; patients are owed transparency and language to describe their symptoms and suffering. It's as if "narcissist" is the forbidden word you must not speak aloud. This is utterly bogus. Narcissism is present within all of us, even the clinicians who are too scared to name it. Refusing to share an NPD diagnosis is part of the reason why many narcissists are unable to access treatment and self-awareness.

If you can name depression, OCD, autism and anxiety, then you can name narcissism. Trust your patient enough that they can overcome the distress accompanied by a diagnosis reveal. Knowledge grants people the choice and agency they deserve to heal. Even with the reality that personality disorders are not curable. Honesty is a form of compassion. Refusing to acknowledge narcissism is erasure of the mentally ill community and silences their pain.

Clinicians are also weary of triggering defensiveness within their patients if they reveal a diagnosis of NPD. If the stigma surrounding narcissism weren't so rampant and connotated with the worst of all imaginable evils, then feelings of defensiveness wouldn't be high. To improve the therapeutic alliance, one must deconstruct the popular conception of narcissism first.

Chapter XVI

“Narcissistic Abuse” Deserves Quotations Marks

Personality traits exist on spectrums, with traits ranging from mild in severity to very severe. Narcissism, in moderation, is a normal and adaptive trait, universally experienced within everyone’s internal world. A personality disorder, however, is defined by the extreme, pervasive, distressing, and dysfunctional expression of traits. Otto Ranl (1911) authored the first psychoanalytical paper explicitly addressing narcissism, followed by Sigmund Freud's On Narcissism (1914).

These early conceptualizations saw narcissism as a defensive mechanism, protecting from low self-worth and diminished self-esteem. Freud further proposed that narcissism exists on a continuum from adaptive, normative to pathological. This all stands today. Heinz Kohut then emphasises in his self-psychology framework that narcissism pathology emerges from disruptions in the development of the self and are vulnerable to feelings of emptiness and depression. In contrast, Otto Kernberg emphasised aggression and intrapsychic conflict. This, I speculate, is where the roots of narcissism-based stigma first found its footing.

Kernberg argued that narcissists rely heavily on idealization, denigration and splitting, and lack the capacity for genuine sadness and guilt, instead experiencing shame, envy and grandiose aggression, and fantasies of specialness is a defensive adaptation emerging from aggressive, cold or indifferent caregivers. Through these theories, NPD was formally introduced into DMS-III in 1980. Social perceptions of NPD today heavily mimic Kernberg’s early and outdated conceptions.

“Narcissistic abuse” is understood as a special pattern of abuse perpetrated by a narcissist.

Narcissist is a superlative term (an adjective describing the highest degree of quality). How do I know that the term is superlative? Everyone has narcissistic traits, as it is a wide spectrum of various traits which are neither inherently moral nor immoral, but essential to understanding collective behaviours and choices. A narcissist is an identity-cantered term which posits a person who exists on the far end of the narcissism spectrum. Thus, a narcissist can only mean someone who experiences narcissistic personality disorder (NPD).

A particularly annoying myth is the claim that there is a meaningful difference between narcissists and people with narcissistic personality disorder. This distinction is frequently invoked to defending stigma by suggesting that criticism of “narcissists” does not extend to those with a formal diagnosis of NPD. I beg to differ. Saying there is a meaningful difference between a narcissist and a person with NPD is like saying there is a meaningful difference between someone with ASD and an autistic person.

Narcissistic personality disorder is a complex personality disorder and neurodivergence characterized by functional and structural neuronal differences. As a result, NPD is regarded as disparate from the norms of neuronormativity (the societal standard for the "right way" to think, feel and behave). Most importantly, NPD is caused by a complicated interplay of genetics and environment and is disproportionately caused by trauma. For this reason, NPD is described as a traumagenic disorder.

"Narcissistic abuse" assumes that there is a distinct form of abuse which is exclusive to narcissists. Pop-psychology and culture typically describe "narcissistic abuse" through patterns of love-bombing, gaslighting, manipulation, devaluation, and discard. Once again, pop-psychology flattens abuse and mental health into a neat package which sells and markets very well for influential content creators pursuing profit, and desperate trauma survivors seeking closure and clarity.

Love-bombing, gaslighting, manipulation, devaluation and discard are not patterns exclusive to narcissists, or disordered individuals. The simple fact is, anyone can abuse, and abuse is a choice. Attributing abusive patterns to a disorder removes agency from the person with said disorder. If you remove the agency of choice from a person and displace it onto their disorder, then you can't hold said person accountable for their actions.

Furthermore, pop-psychologists and grifters fail to mention that nowhere is the term "abuse" mentioned in the DSM-5-TR criteria for NPD. Many will exploit the criteria of "interpersonal exploitativeness" to justify their use of the term "narcissistic abuse," without considering that clinically; one requires only 5 out of 9 criteria to quality for a diagnosis of NPD. "Interpersonal exploitativeness" is not synonymous with abuse, and exploitation can manifest in many nuanced forms.

A "lack of empathy" is inherently amoral and can't be argued as rationalization that narcissists are always "evil" or "abusive." Empathy includes cognitive empathy and affective empathy. Mainly, narcissists struggle with affective empathy, which is the ability to feel the emotions of others. Cognitive empathy is the ability to intellectualize and understand the feelings and behaviours of other people, regardless of whether you share their feelings or not. Neither cognitive empathy nor affective empathy is necessary to engage in compassionate behaviours, as compassion is a desire to extend help towards others even if you do not understand or feel their feelings.

Using a traumagenic disorder to describe abuse IS ableist. Whether it's "narcissistic abuse," "sociopathic abuse," "borderline abuse," "autistic abuse," "bipolar abuse," "schizophrenic abuse," and so on and so forth. Demonizing narcissists is part of a broader belief that people with disabilities and mental illness are inferior. Trauma survivors who describe (or armchair - diagnose) their abuser as a "narcissist" feel validated by the term "narcissistic abuse." It is important to stress that rejecting the term "narcissistic abuse" is NOT about policing trauma survivors, but rather about ensuring all trauma survivors can exist safely in community with one another, including those with NPD.

Let's be clear; BPD "favourite person" and the narcissist's "supply" are the same damn thing. Both exist for external validation. So why is one more demonized and the other more infantilized? The borderline's need for external validation is seen as tragic and endearing. While for narcissists, it is seen as manipulative and entitled. Both are seeking validation to regulate their internal self-esteem. BPD and NPD are a lot more similar than many people like to believe. One is not better than the other. Cluster Bs must stand together in solidarity.

Let's not forget to address "covert" and "overt" narcissism. I despise these labels. They are labels used to refer to grandiose and vulnerable narcissism, subsets of narcissism. However, the issue with the "covert" and "overt" labels is that they are used to gauge just how well someone can mask or hide their narcissistic traits in society, or for lack of better words, how visibly narcissistic someone is. It's as if the words "covert" and "overt" are dials on a telescope. This type of narrative is ableist in and of itself. Stop trying to find the narcissism in someone so you can go ahead on your armchair diagnosing rampages.

"BPD is caused by narcissists" is a prevailing saying which circulates inside BPD circles, a rhetoric parroted by BPD people. I hate to break it to borderline supremacists, but if you have BPD, then it's more likely that your armchair diagnosed abuser had BPD instead of NPD. Narcissist has obviously become a scapegoated and catch-all phrase for any abuser. The BPD community has fallen prey to the stigmatizing narratives against the Cluster B community and have thus embodied a false position of superiority over the rest of the cluster. As someone with BPD, I'd hate to knock them off their high horse, but if we want to achieve Cluster B solidarity then it must be done. BPD is approximately five times more common among first-degree biological relatives of individuals with the disorder than in the general population. Remember, personality disorders are a complex interplay between both genetics and the environment. Abuse and trauma cause personality disorders. One disorder does not cause another disorder. End of story.

So why is the allure of stigma as strong as it is?

Dr. Ramani Durvasula is an American clinical psychologist with a PhD and clinical 'expertise' in narcissism. She has a prominent online presence and personality. It is important to remember that as frustrating as the widespread demonization of NPD and

other disorders is, the stigma is amplified in high scale by authorities who misuse their power to exploit vulnerable people, including trauma survivors seeking closure. Dr. Ramani has consistently leveraged her authority to gain influence in the online space. She uses the promise for her degrees to post YouTube thumbnails such as the ones below, thereby turning mental health into a cat and mouse game, a lesson in how to subvert power dynamics of control and manipulation.

Can you imagine how tired narcissists must be to constantly be scapegoated, demonized and vilified? Dr. Ramani is one example among countless people. Neat and cheap content markets faster and much more profitably than complex consideration and compassion for the neurodivergent community. There is also a clear financial economy behind the popularity of “narcissistic abuse.” Online personalities from coaches, influencers and authors profit from branding interpersonal harm with a label that is already inundated with fear and moral panic. This selfish commodification comes at the direct expense of people living with personality disorders, who become collateral damage in the pursuit of clicks, ego, and dollar signs.

Chapter XVII

Antisocial Personality Disorder

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviours, as indicated by repeatedly performing acts that are grounds for arrest.

2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.

4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.

5. Reckless disregard for safety of self or others

6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.

7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behaviour is not exclusively during the course of schizophrenia or bipolar disorder.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had evidence of conduct disorder with onset before age 15 years (Criterion C). Conduct disorder involves a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviours characteristic of conduct disorder falls into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. This means something like truanting school frequently, accessing drugs and alcohol before the legal age and drinking it frequently, getting into violent altercations in school, stealing from friends and family and stores and so on.

What do I think of the diagnostic criteria as someone who is antisocial?

1. Well, I know of people with ASPD who have had run-ins with the law. I have engaged in petty criminal activity myself. Don't tell anyone I told you that (wink wink). Criminality is not always indicative of ASPD, and it is important to ascertain the broader context within which criminality occurs. Criminal activity is not inherent to ASPD. Nor does criminality have to imply maliciousness or a felony.

2. From what I understand, the lying and deceitfulness of someone with ASPD is usually learnt as a trauma response because we were raised in an environment where we could be punished for the truth, and also because people with ASPD, myself included, don't see manipulation as an inherently bad thing. Manipulation and deception don't always hurt other people.

3. For instance, a sex worker is manipulative and deceptive when serving her client and so is any service-based job really. I suppose this is also where the assumption that people with ASPD are charming and glib come from. The truth is, it is all subjective and in the eye of the beholder. Many have told me I am charming. Many have also told me I am awkward. It is all in the eye of the behold and much of interpersonal relationships are about perception, and everyone's perception is going to be different. Not everyone with ASPD would describe themselves as charming.

4. This one is an overlap with BPD. Again, people with ASPD are neurodivergent and so they have neuronal differences in their brain structure which predisposes them to impulsivity.

5. I honestly think that if you have been through severe trauma and abuse, you're going to naturally have anger issues and resentment. The world failed you and you didn't have an outlet for justice most of the time, so of course you're going to be angry.

6. I want to emphasise the lack of safety for themselves as well, which people tend to ignore. But people with ASPD that I know of and have interacted with have been hurt and not bothered getting checked up by a doctor or just don't care if almost came close to getting injured or are overdosing or doing risky substances. I suppose they learnt to navigate a traumatic childhood by not giving a fuck. People with ASPD are more likely than the general population from suicide or injuries or accidents.

7. I think this one ties in very neatly with the failure to plan ahead. And I would imagine people with ASPD getting bored extremely easily and as being quite novelty-seeking. I can't imagine them enjoying a 9-5 very much.

8. Lacking remorse is not a requirement to being a good person. A lot of the rationalizations that people with ASPD engage in are "it's everyone for themselves," "no one supported me when I was low," and "everyone's scum, at least I admit it." I have failed to apologize for a lot of the behaviours I have engaged in, although to be fair a lot of the behaviours I have engaged in warranted more than just an apology. I have a very difficult time apologizing and genuinely feeling remorse, even after all these years.

Something to work on. At this time of this writing, I am only 20. I still have a very long way to go.

Chapter XVIII

Anti-Society

I led this writing with the term “sociopath.” Sociopath is a slur; in the same way “narc” is a slur. Only the ASPD and NPD community can reclaim these words. Anyone else is simply a bigot.

The clinical descriptor for a sociopath is an antisocial person, as in antisocial personality disorder.

I prefer anti-society. Individuals with ASPD can be social and charming, or introverts and loners.

Everyone needs social connections. Even someone with ASPD is grateful for a genuine connection. It’s a universal human need.

To be anti-society means to be anti-societal norms. We craft our own rules and reality, subversive and deviant from the common path.

We do not trust authority figures, for power can corrupt as we know all too well. We have been faced with the arbitrariness of rules, and moral sticks. We have been abandoned and hurt by “good people” and witnessed the goodness in “bad people” who did not judge us or look down on us.

We are anti-society. Or at least, I am.

Chapter XIX

Criminality as a Pathology?

Social constructionist perspectives deem ASPD is a diagnosis which is socially constructed, with no empirical validity. It is merely a means, apparently, for psychiatrists to expand their power over the criminal justice system.

Philippe Pinel is regarded as the father of psychiatry, first described the phenomenon of violent behaviour in otherwise sane and cognitively sound people as mania without delirium, the first attempt to medicalize violent and criminal behaviour Then, James Cowles Prichard called it “moral insanity,” an essentialist framework which posited that some individuals were inherently immoral from a medical standpoint. Prichard reckoned “moral insanity” could function as a legal defence in criminal court cases due to the defendant’s marked impulsivity. Altogether, these early conceptualizations formed the basis for the official codification of ASPD into the DSM-III in 1980. Social constructionists say this pathology is contingent on the societal expectation that bad people must also be mad and argue that ASPD must be de-medicalized.

As evidence, social constructionists cite the higher rate of ASPD within the prison population as proof of the medicalization of criminality. An important consideration is whether ASPD as a diagnosis functions as a form of social control through which criminals are segregated from the rest of society as an outgroup, just as it has done with homosexuality and “hysteria” in the past.

Now, I am antisocial. I have never been diagnosed within the criminal system or had contact with the criminal system. An antisocial person values autonomy, control and freedom. One of their worst fears is being controlled. One of my worst fears is prison. I recall one time I was sectioned by police for an overdose. I was locked inside a police wagon. If only you had seen my fury. I was banging and kicking all around the inside of the wagon.

What is my opinion on the social constructionist viewpoint? I reject it. ASPD is a valid diagnosis, but I also hold consideration for the way ASPD has been weaponized by unethical and incompetent clinicians against people in the criminal justice system. People with ASPD are neurodivergent and have observable neuronal differences in their brain which accounts for why ASPD should exist as a diagnosis. Neuroimaging research confirms that there are biological differences in people with personality disorders. With ASPD, the exposure to early childhood trauma results in a lack of empathy, impulsivity, an inability to plan for the future, novelty-seeking and an extreme sense of boredom, and difficulty accessing their own emotions. It is as valid a diagnosis as C-PTSD and is one of many ways trauma can manifest.

However, despite ASPD being a neurodivergence and the lived experience of trauma survivors, psychiatrists continue to misuse the diagnosis within the criminal justice to condemn someone as “evil, irredeemable, and a continued threat towards society.” The stereotypes of ASPD are used as a weapon of moral condemnation. ASPD as a label works fabulously if your intention is to convince the judge to hand down a life sentence or death penalty. It is important not to undermine the eugenics which underpin the stereotypes and weaponization of ASPD. Eugenic theories have always viewed character as unfixable and hereditary. These unethical psychiatrists love to forget the simple fact that ASPD traits naturally remit over time and are not static in severity

It is ironic that people labelled with ASPD are called “monsters” when the law enforcement system itself frequently abuses prisoners, increasing their reoffending rate. Police officers frequently use someone else’s trauma as a reason to enact state violence. The law does not protect trauma survivors. Approximately 70% of Cluster B diagnoses come from correctional or forensic settings. These settings are not designed for rehabilitation or reintegration into society. Being an advocate for the mentally ill community means being a prison abolitionist.

Quincy Allen was a person, like you and I, who endured severe childhood abuse, mental health problems, repeated suicide attempts and escalating psychosis. Mental health “professionals” were undecided as to whether he was psychotic, depressed or antisocial. When one expert diagnosed him with ASPD, he discontinued Quincy’s medication. The judge ruled in favour of the death penalty, on the opinion that Quincy was not mentally ill, as if ASPD is in and of itself not an illness. The ASPD label became the decision between life and death.

The harsh environment of prison fosters a need for daily survival. And so, many prisoners will adopt ASPD traits to survive. This does not mean they have ASPD. It means that they are using the defence and survival mechanisms appropriate to their environment.

Grassroots advocacy, reforms, standardization of legal language surrounding psychiatric diagnoses, interdisciplinary guidance for attorneys and legal experts and trauma-informed models can all help combat stigma and discrimination.

Chapter XX

Histrionic Personality Disorder

I would like to preface this chapter by stating that I do not have HPD, and therefore I want to be careful about impersonating the experiences of people with HPD. However, I would still like to do my best in shedding light on this disorder instead of erasing it from my writings all together, as HPD is part of the Cluster B and this is my effort in showcasing Cluster B solidarity.

Below are the DSM-5 criterions for HPD:

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the centre of attention.

2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour.

3. Displays rapidly shifting and shallow expression of emotions.

4. Consistently uses physical appearance to draw attention to self.

5. Has a style of speech that is excessively impressionistic and lacking in detail.

6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.

7. Is suggestible (i.e., easily influenced by others or circumstances).

8. Considers relationships to be more intimate than they actually are.

Histrionic personality disorder is basically about needing to be the centre of attention, often in dramatic, performative, theatrical, or sexually provocative ways. People with HPD can be charming and lively at first, but interpersonal relationships wane over time as the need for attention becomes draining or hard to make space for. Sometimes, the need for attention manifests in fabricating details and stories, excessive flattery, gift-giving, exaggeration of scenarios, fishing for compliments, bold outfits, and sexual behaviour. Like most people with Cluster Bs, they are novelty seeking and love instant gratification, usually because of how easily bored we can get.

Like BPD, a person with HPD's emotions shift rapidly as well. A prominent difference is that the emotions of someone with BPD are intense and painful, while the emotions of someone with HPD present in a shallow way. HPD causes less impairment and is much more rare than the other personality disorders.

The term "histrionic" comes from the Latin word for "actor" and is derived from the outdated and misogynistic concept of hysteria, historically weaponized against people assigned female at birth. Early theories blamed a "displaced womb" or past trauma, while modern perspectives focus on the intersection of genetics and environmental influence, particularly childhood experiences of abuse and/or trauma. Essentially, the disorder can develop when early attention needs aren't met, leading to a pathological need to be noticed.

Chapter XXI

HPD Stigma

The biggest issue seems to be the undermining of HPD as a legitimate diagnosis. One of the reasons for this is its frequent comorbidity with NPD and BPD, so much so that psychiatrists are considering merging the diagnoses together. Word on the street is that psychologists are debating removing HPD as a diagnosis from the next edition of the DSM to either be merged with or reclassified as a subtype of BPD or NPD. A person with HPD and other comorbidities may receive more clinical attention and care for their comorbidities due to how under-researched and misunderstood HPD is, and comorbidities may subsume HPD traits which are considered relatively benign. The lack of information on HPD is due to it being one of the rarest mental disorders present in society.

Community is how people relate to one another, form genuine connections and a base for meaningful support. People with HPD often lack community not only due to the rarity of their disorder but also due to the lack of knowledge surrounding it.

I am not going to pretend I experience the disorder myself or understand the disorder to the extent that someone with HPD would. I can't say whether I believe that HPD should be removed from the DSM or not. But it is important for me to include the voices of people with HPD and listen to what they have to say about this. And so, I have gathered as much information as I could from the little and small HPD online communities which do exist.

Some with HPD have expressed that it would be a dreadful mistake to remove HPD from the DSM, and have expressed that the reason HPD may be misunderstood so much is due to people with the disorder walking around undiagnosed because they are never picked up or cared for by clinicians and are never educated on HPD due to the lack of education. People with HPD existing within small communities believe that these small communities are a testament to the fact that they require specialized care and validation. One person with HPD described herself as not haughty or arrogant enough for NPD and quite empathic and not moody and dependent enough for BPD. Rather, she existed within the confines of HPD and did not feel they reflected the traits or personality of a narcissist or borderline. They admit being attractive, easily liked, eccentric, and have a dire and grasping need for attention, which has even landed them in some serious trouble. They admit that they have become a pathological liar just to get attention, by crafting an image or persona around themselves. They have been described as bubbly, wild, dramatic, extra and slutty, and with a Broadway style level of animate-ness. HPD folks are hoping to validate the disorder in the eyes of professionals and hoping things will work out in their favour.

One person even expressed how it bothered them that the conception around HPD is that they say things which lack depth or inside knowledge. They say that if someone if speaking on a topic they will do some quick research before responding or chiming in or just stay silent despite how uncomfortable silence is for them.

This is an important point as it once again reminds that HPD, like other disorders, is a spectrum and it can manifest itself in so many ways. Not everyone with HPD is going to have the same experience of HPD.

Another person with HPD said that they prefer to remain a “mystery” or an enigma by catching themself short before they divulge too much, and this is how they prefer their persona, which they recognize may seem vague to someone on the outside, but again this functions as a defence mechanism against oversharing with people who may not share your best interests at heart.

Another one said that they believe that their inclination to speak on metaphors and use vague language is a defence mechanism against being dismissed if they allow themselves to be more vulnerable or intimate. They mourn the fact that they are often objectified or sexualized before their opinions, thoughts and feelings are taken seriously. Learning to be indirect was a defence mechanism to avoid being yelled and avoid the confrontation that can arrive with being too direct in communication. HPD women also speak of how they find that men tend to find them more attractive when they are simply pretty and have a lack of depth, and this may be due to the persona of the naive and dumb but pretty girl. Men may assume that a girl like this is “easy game.”

Which pisses me off to no end. Many men have not opposed patriarchy and refuse to acknowledge the depth of a woman, otherwise their ego and fragile sense of superiority is threatened. In this way, they target vulnerable women who are suffering from trauma backgrounds and mental disorders to pursue their interests.

Boundary-setting is difficult for anyone who has a trauma background, and one person with HPD commented on how they are actively trying to work on their boundary-setting skills without coming across as too controlling or adversarial.

They also mention how they prefer to be regarded as “approval-seeking” rather than “attention-seeking.” This need for approval is what leads to the need to externalise their sense of self onto others, their thoughts and opinions and memories and identities and emotions and questions, revealing everything on their sleeve. They say they have trouble accessing themselves when they are not externalizing to others, and they say “overshare” does not even begin to describe how they operate because they do not know how to live inside of themselves due to the fractured sense of self, even at the expense of their boundaries and values and connection to themselves (they are estranged from themselves).

They say what differentiates them from narcissists is that they do not lack empathy or enter cycles of devaluation, but still require the attention or approval of others, and dive headfirst into intimacy.

Ultimately, a lot of the behaviours and traits of people with HPD are survival mechanisms.

Chapter XXII

Still Human

I’m still here. I’m still human. A messy, contradictory, beautiful human.

Suicide Hotlines

Below are suicide hotlines for anyone who is experiencing distressing or suicidal thoughts. I have provided hotlines for countries where I believe a majority of my readers may be based. Find a Helpline is a global directory of helplines which helps you locate helplines around the world.

Australia

Beyond Blue – 1300 22 4636

Lifeline – 13 11 14

MensLine Australia – 1300 78 99 78

1800RESPECT – 1800 737 732

13YARN – 13 92 76

Kids Helpline – 1800 55 1800

Suicide Call Back Service – 1300 659 467

1800 FULL STOP – 1800 385 578

US

Crisis Text Line – 741741

988 Suicide and Crisis Lifeline – 988

Trans Lifeline - (877) 565-8860

Disaster Distress Helpline – 800-985-5990

TrevorLifeline - (866) 488-7386

Veterans Crisis Line – 838255

YouthLine - (877) 968-8491

UK

Samaritans – 116 123

NHS 111 – Dial 111 (urgent mental health support)

Shout Crisis Text Line – Text SHOUT to 85258

Papyrus HOPELINE247 (Under 35) – 0800 068 4141

CALM (Campaign Against Living Miserably) – 0800 58 58 58

Canada

Talk Suicide Canada – 1-833-456-4566

Canada Suicide Crisis Helpline – 988

Crisis Text Line Canada – Text 45645

Hope for Wellness Helpline (Indigenous Peoples) – 1-855-242-3310

Kids Help Phone – 1-800-668-6868 or text CONNECT to 686868

New Zealand

1737 – Call or text 1737

Suicide Crisis Helpline – 0508 TAUTOKO (828 865)

Lifeline – 0800 543 354 or text HELP to 4357

Youthline – 0800 376 633 or text 234

Samaritans Aotearoa – 0800 726 666

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